

Billing Information

Wisconsin Medicaid must receive properly completed claims within 365 days from the date the service was provided.

Claim Submission

All claims, whether electronic or paper, are subject to the same Medicaid processing and legal requirements.

Electronic Billing

Child care coordination (CCC) providers are encouraged to submit claims electronically. Electronic claims submission:

- Reduces processing time.
- Eliminates manual handling of claims.
- Reduces both billing and processing errors.

Wisconsin Medicaid provides free software for billing electronically. For more information on electronic billing:

- Refer to the Claims Submission section of the All-Provider Handbook.
- Contact the Electronic Media Claims (EMC) Department at (608) 221-4746. Ask to speak with an EMC coordinator.

If you are currently using the free software and have technical questions, please contact Wisconsin Medicaid's software customer service at (800) 822-8050.

Paper Claim Submission

Providers submitting paper claims are required to use the HCFA 1500 claim form (dated 12/90). Appendices 2 and 3 of this handbook contain completed samples of HCFA 1500 claim forms for CCC services. Refer to Appendix 1 of this handbook for HCFA 1500 claim form completion instructions.

Wisconsin Medicaid denies claims for CCC services submitted on any paper claim form other than the HCFA 1500 claim form.

Wisconsin Medicaid does not provide the HCFA 1500 claim form. Providers may obtain these forms from any vendor that sells federal forms.

Where to Send Your Claims

Mail completed HCFA 1500 claim forms for reimbursement to the following address:

Wisconsin Medicaid
Claims and Adjustments Unit
6406 Bridge Road
Madison, WI 53784-0002

Claim Submission Deadline

Wisconsin Medicaid must receive properly completed claims within 365 days from the date the service was provided. This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

Exceptions to the 365-day claim submission deadline and requirements for submission to Late Billing Appeals can be found in the Claims Submission section of the All-Provider Handbook. Providers may access the handbook on-line at www.dhfs.state.wi.us/medicaid/.

Recipient Identification

Care coordinators are required to use the mother's Medicaid ID number when billing for CCC services.

If the mother becomes ineligible for Wisconsin Medicaid while receiving CCC services, providers may bill Wisconsin Medicaid for those services using the eligible child's Medicaid ID number. Providers are required to document in the recipient's file the reason for using the child's Medicaid ID number when billing for CCC services.

Billed Amounts

Providers are required to bill their usual and customary charge for the service performed. The usual and customary charge is the provider's charge for providing the same

service to persons not entitled to Wisconsin Medicaid benefits. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients.

Providers may not discriminate against Wisconsin Medicaid recipients by charging Medicaid a higher fee for the same service than that charged to a private-pay patient. For providers who have not established usual and customary charges, the charge should be reasonably related to the provider's cost to provide the service.

Reimbursement

Providers are reimbursed at the lesser of their usual and customary charge or the maximum allowable fee established by the Department of Health and Family Services (DHFS).

The maximum allowable fee is the amount Wisconsin Medicaid will pay a provider for an allowable procedure code. Refer to Appendix 16 of this handbook for a copy of the Wisconsin Medicaid maximum allowable fee schedule for CCC services.

To obtain subsequent maximum allowable fee schedules, or to ensure you have the most recent fee schedule, you may:

- Purchase a paper schedule by writing to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

Providers may contact Provider Services at (800) 947-9627 or (608) 221-9883 for the cost of the fee schedule.

- Download an electronic version from Wisconsin Medicaid's Web site using directions located in the Claims Submission section of the All-Provider Handbook. Wisconsin Medicaid's Web site is located at www.dhfs.state.wi.us/medicaid/.

Procedure Codes

All claims submitted to Wisconsin Medicaid must include procedure codes. Allowable HCFA Common Procedure Coding System (HCPCS) codes for CCC services are listed in

It is vital that you use the correct procedure codes, diagnosis codes, and modifiers when billing for CCC services:

Procedure Codes

- W7095 Risk Assessment - Child Care Coordination.
- W7096 Initial Care Plan Development - Child Care Coordination.
- W7097 Ongoing Child Care Coordination and Monitoring.

Diagnosis Codes

- V61.8 Other specified family circumstances.
- V61.9 Unspecified family circumstances.

Use V61.8 when billing for:

- Recipients who score 70 or more points on the Family Questionnaire (initial risk assessment).
- When billing procedure codes W7096 or W7097.

Use V61.9 when billing for:

- Recipients who score fewer than 70 points on the Family Questionnaire.

Remember to use a modifier to indicate the recipient's risk assessment score when billing for procedure code W7095. Please refer to Appendix 4 of this handbook for the appropriate modifiers.

Claims submitted for risk assessments (procedure code W7095) must include a modifier indicating the recipient's total risk assessment score.

the shaded box on the previous page and in Appendix 4 of this handbook. Claims or adjustments received without the appropriate HCPCS codes are denied.

Diagnosis Codes

Claims submitted for CCC services must include either diagnosis code V61.8 (other specified family circumstances) or V61.9 (unspecified family circumstances).

Use diagnosis code:

- V61.8 when billing on behalf of recipients who score 70 points or more on the Family Questionnaire (i.e., those who are determined eligible to receive services).
- V61.8 when billing procedure codes W7096 and W7097.
- V61.9 when billing on behalf of recipients who score fewer than 70 points (i.e., those who are assessed but determined ineligible to receive services).

Wisconsin Medicaid will deny claims if providers use other diagnosis codes when billing for CCC services.

Time Units

When billing for risk assessment (W7095) and initial care plan development (W7096), always bill for one unit.

Round time units to the nearest tenth of an hour when billing for ongoing care coordination and monitoring (W7097).

Refer to Appendix 6 of this handbook for more information on rounding guidelines for CCC services.

Modifiers

Claims submitted for risk assessments (procedure code W7095) must include a modifier indicating the recipient's total risk assessment score.

Allowable modifiers are located in Appendix 4 of this handbook. Claims for risk assessments that do not include the appropriate modifier are denied.

Follow-Up to Claim Submission

The provider is responsible for initiating follow-up procedures on claims submitted to Wisconsin Medicaid. Processed claims appear on the Remittance and Status (R/S) Report either as paid, pending, or denied. Wisconsin Medicaid will take no further action on a denied claim until the provider corrects the information and resubmits the claim for processing.

If a claim was paid incorrectly, the provider is responsible for submitting an Adjustment Request Form to Wisconsin Medicaid. Refer to the Claims Submission section of the All-Provider Handbook for more information on filing Adjustment Request Forms.

To be reimbursed for additional ongoing care coordination time which may have been omitted from the original claim, providers are required to file an Adjustment Request Form.